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HOUSE BILL 520
By Bowers

AN ACT to enact the Managed Care Consumer Protection Act.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This act shall be known and may be cited as the "Managed Care Consumer Protection Act".

SECTION 2. The purpose of this act is to ensure that enrollees receive adequate health care services under a managed care system. The intent of this act is to ensure that:

(a) Enrollees have full and timely access to clinically and culturally appropriate health care personnel and facilities;

(b) Enrollees have adequate choice among health care professionals who are accessible and qualified;

(c) Enrollees and physicians have open communication with one another;

(d) Enrollees have access to comprehensive pharmaceutical services;

(e) Enrollees have access to information regarding limits on coverage of experimental treatments;

(f) There is high quality of care within a managed care plan;

(g) Appropriate medical personnel make medical decisions;

(h) Health care professionals within a plan are practitioners in good standing;

(i) Managed care plan data are available as appropriate;

(j) The public has full access to information regarding health care service delivery within plans;

(k) The state has authority to oversee all managed care plans;

(l) The resolution of enrollee complaints in a managed care system is done fairly; and

(m) Enrollee grievances and appeals are resolved in a timely manner.

SECTION 3. As used in this act, unless the context requires otherwise:

(a) “Appeal” means a formal process whereby an enrollee, whose care has been reduced, denied, or terminated, or whereby the enrollee deems the care inappropriate, may contest an adverse grievance decision by the health care services plan.

(b) “Emergency” means a medical condition, the onset of which is sudden and unexpected, that manifests itself by symptoms of sufficient severity, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably assume that the condition requires immediate medical treatment, and could expect that the absence of medical attention to result in serious impairment to a bodily function or place the person’s health in serious jeopardy.

(c) “Enrollee” means an individual who is enrolled in the managed care entity.

(d) “Expedited review” means a review process which takes no more than seventy-two (72) hours after the review is commenced.

(e) “Experimental treatment” means treatment that, while not commonly used for a particular condition or illness, nevertheless is recognized for treatment of the particular condition or illness, and there is no clearly superior, non-experimental treatment alternative available to the enrollee.

(f) “Grievance” means a written complaint submitted by or on behalf of the enrollee.

(g) “Health care provider” means a clinic, hospital physician organization, preferred provider organization, independent practice association, or other appropriately licensed provider of health care services or supplies.

(h) “Health care professional” means a physician or other health care practitioner providing health care services.

(i) “Health care services” means services for the diagnosis, prevention or treatment of a health condition, illness, injury or disease.

(j) “Managed care entity” means any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health services organization, preferred provider organization, third-party administrator, or any person or entity that establishes, operates or maintains a network of participating health care professionals.

(k) “Managed care plan” means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in the plan, with financial incentives for persons enrolled in the plan to use the participating health care professionals and procedures covered by the plan.

(l) “Participating practitioner” means a health care professional who has entered into an agreement with a managed care entity to provide health care services to an enrollee in the managed care plan.

(m) “Point of service option” means an option for the enrollee to choose to receive service from a non-participating health care professional or provider.

(n) “Primary care practitioner” means a health care professional under contract with the plan, who has been designated by the plan to coordinate, supervise, and/or provide ongoing care to the enrollee.

(o) “Prudent layperson” is a person without specific medical training for the illness or condition in question who acts as a reasonable person would under similar circumstances.

(p) “Quality assurance” means the ongoing evaluation of the quality of health care provided to enrollees.

SECTION 4. This act shall apply to each managed care entity operating within the state.

SECTION 5. (a) Each managed care plan shall include a sufficient number and type of primary care practitioners and specialists, throughout the service area, to meet the needs of enrollees and to provide meaningful choice. Each managed care plan shall demonstrate that it offers:

(1) An adequate number of accessible acute care hospital services, within a reasonable distance and/or travel time;

(2) An adequate number of accessible primary care practitioners, within a reasonable distance and/or travel time. “Primary care practitioner” includes family practice and general practice physicians, internists, obstetrician/gynecologists and pediatricians;

(3) An adequate number of accessible specialists and sub-specialists, within a reasonable distance and/or travel time. When the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees shall have access to non-participating health care professionals.

(4) The availability of specialty medical services, including physical therapy, occupational therapy, and rehabilitation services; and

(5) The availability of non-panel specialists, when a patient’s unique medical circumstances warrant it.

(b) Each managed care plan shall provide for continuity of care with established primary care practitioners, when the health care professional’s contract is terminated.

The plan shall allow an enrollee, at no additional out-of-pocket cost, to continue receiving services from a primary care practitioner whose contract with the plan is terminated without cause. This continuation shall be effective for sixty (60) days when the enrollee requests continued care.

(c) Each managed care plan shall provide telephone access to the managed care plan for a sufficient time during business and evening hours to ensure enrollee access for routine care, and twenty-four (24) hour telephone access to either the plan or a participating provider or practitioner, for emergency care or authorization for care.

(d) Each managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided below for emergency services. Such standards shall include appointment scheduling guidelines based on the type of health care service, including prenatal care appointments, well-child visits and immunizations, routine physicals, follow-up appointments for chronic conditions, and urgent care.

(e) Each managed care plan shall cover and reimburse expenses for emergency care obtained, without prior authorization, in a situation where a prudent layperson could reasonably believe the condition required immediate attention at the nearest facility.

(f) Each managed care plan shall demonstrate that it has developed an access plan to meet the needs of vulnerable and under served populations.

(1) The plan shall provide culturally appropriate services to the greatest extent possible.

(2) When a significant number of enrollees in the plan speaks a first language other than English, the plan shall provide access to personnel fluent in a language other than English, to the greatest extent possible.

(3) The plan shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the plan.

(g) Each managed care plan shall hold harmless an enrollee, against any claim from a participating practitioner in the managed care plan, for payment of the cost of covered health services.

SECTION 6.

(a) Each enrollee shall have adequate choice among managed care plan health care professionals who are accessible and qualified.

(b) Each managed care plan shall permit an enrollee to choose his or her own primary care practitioner from a list of health care professionals within the plan. A managed care entity shall regularly update its list of health care professionals, and the list shall include:

(1) A sufficient number of primary care practitioners who are accepting new enrollees; and

(2) A sufficient mix of primary care practitioners that reflects a diversity that is adequate to meet the needs of the enrolled population's varied characteristics, with respect to age, gender, race and health status.

(c) Each managed care plan shall develop a system to permit an enrollee to use a medical specialist primary care practitioner, if the enrollee's medical condition warrants it. This provision includes any enrollee suffering from a chronic disease as well as one with any other special need.

(d) Each managed care plan shall provide continuity of care and appropriate referral to specialists within the plan, when specialty care is warranted.

(1) An enrollee shall have access to medical specialists on a timely basis.

(2) An enrollee shall be provided with a choice of specialists when a referral is made.

(e) Each managed care plan shall offer a point-of-service option.

(1) The point-of-service option may require that the enrollee in the plan pay a reasonable portion of the costs of such out-of-plan care.

(f) Each plan shall provide an enrollee with access to a consultation for a second opinion.

SECTION 7.

(a) Each managed care plan shall provided coverage for all FDA-approved drugs and devices, whether or not that drug or device has been approved for the specific treatment or condition, so long as the primary care practitioner or other medical specialist treating the enrollee determines the drug or device is medically necessary and appropriate for the enrollee's condition.

(b) Each managed care service plan shall establish and operate a drug utilization review program that includes the following:

(1) Retrospective review of prescription drugs furnished to an enrollee; and

(2) Education of physicians, enrollees and pharmacists regarding the appropriate use of prescription drugs.

(c) Each managed care plan shall provide for a drug utilization review program with ongoing periodic examination of data on outpatient prescription drugs to ensure a quality therapeutic outcome for an enrollee.

(1) The drug utilization review program's primary emphasis is to enhance quality of care for enrollees by assuring appropriate drug therapy.

(2) The drug utilization review program shall include the following:

(i) Clinically relevant criteria and standards for drug therapy;

(ii) Nonproprietary criteria and standards, developed and revised through an open, professional consensus process; and

(iii) Interventions which focus on improving therapeutic outcomes.

(3) The confidentiality of the relationship between enrollees and health care professionals shall be protected at all times.

(d) The health care services plan shall provide an educational outreach program as part of the drug utilization review program.

(1) The outreach program shall be directed to enrollees, pharmacists and other health care professionals.

(2) The outreach program shall emphasize the appropriate use of prescription drugs.

(e) Prospective review of drug therapy may only deny services in case of enrollee ineligibility, coverage limitation, or fraud.

(f) The prescribing health care professional shall determine the appropriate drug therapy for the enrollee; a substitution may not be made without the direct approval of the prescribing health care professional.

SECTION 8. (a) A managed care plan which limits coverage for services shall define the limitation and disclose the limits in any agreement or certificate of coverage. This disclosure shall include:

(1) Who is authorized to make such determination; and

(2) The criteria the plan uses to determine whether a service is experimental.

(b) A managed care plan that denies coverage for an experimental treatment, procedure, drug or device, for an enrollee who has a terminal condition or illness shall provide the enrollee with a denial letter within twenty (20) working days of the submitted request. The denial letter shall include:

(1) The name and title of the individual making the decision;

(2) A statement setting forth the specific medical and scientific reasons for denying coverage;

(3) A description of alternative treatment, services, or supplies covered by the plan, if any; and

(4) A copy of the plan's grievance and appeal procedure.

SECTION 9. (a) The managed care plan shall develop comprehensive quality assurance standards, adequate to identify, evaluate and remedy problems relating to access, continuity and quality of care. These standards shall include:

(1) An ongoing, written, internal quality assurance program;

(2) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(3) Performance and clinical outcomes-based criteria;

(4) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(5) A plan for data gathering and assessment (as provided in Section 10); and

(6) A peer review process.

(b) Each managed care plan shall have a process for selection of health care professionals who will be on the plan's participating practitioner list, with written policies and procedures for review and approval used by the plan:

(1) The plan shall establish minimum professional requirements.

(2) The plan shall demonstrate that it has consulted with appropriately qualified health care professionals to establish the requirements.

(3) The plan's process shall include verification of the individual practitioner's license, any history of suspension or revocation, civil liability claims history and any criminal conviction.

(4) Each managed care plan shall establish a formal, written, ongoing, process for the re-evaluation of all participating physicians within a specified number of years after the initial acceptance.

(i) Re-evaluations shall include updates of the previous review criteria and an assessment of the performance pattern based on criteria including enrollee clinical outcomes, number of complaints and malpractice actions.

(c) The plan shall not use a health care professional beyond, or outside of, his or her legally authorized scope of practice.

SECTION 10.

(a) The managed care plan shall provide information on a plan's structure, decision-making process, health care benefits and exclusions, cost and cost sharing requirements, list of contracting providers and health care professionals as well as grievance and appeal procedures to all potential enrollees, all enrollees covered by the plan, and to the department of commerce and insurance.

(b) The managed care plan shall collect and report annually by not later than December 31 to the department of commerce and administration specified data including:

(1) Gross outpatient and hospital utilization data;

(2) Enrollee clinical outcome data;

(3) The number and types of enrollee grievances or complaints during the year, the status of decisions, and the average time required to reach a decision; and

(4) The number, amount and disposition of malpractice claims resolved during the year by the managed care plan and any of its participating health care professionals.

(c) All data, specified in subsections (a) and (b), are public records and shall be available to the public during regular office hours.

(d) The managed care plan shall establish written policies and procedures for the handling of medical records and enrollee communications to ensure enrollee confidentiality.

(e) The managed care plan shall ensure the confidentiality of specified enrollee information, including, but not limited to, prior medical history, medical record information and claims information, except where disclosure of this information is required by law.

(f) The managed care plan shall be prohibited from releasing any individual patient record information, unless such a release is authorized in writing by the enrollee.

SECTION 11.

(a) The managed care plan shall appoint a medical director who is a licensed physician in Tennessee. The medical director is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan.

(b) The managed care plan shall inform each enrollee of the financial arrangements between the plan and contracting physicians and pharmacists, if those arrangements include incentives or bonuses for restriction of services.

SECTION 12.

(a) The managed care plan shall provide written notification to each enrollee, in a language the enrollee understands, regarding the right to file a grievance. At a minimum, notification shall be given:

(1) Prior to enrollment in the plan; and

(2) At the time care is denied or limited under the plan.

(b) At the time of a denial, the plan shall notify the enrollee of the right to file a grievance:

(1) The notice shall be written;

(2) The notice shall include the reason for denial, the name of the individual responsible for the decision, the criteria for determination, and the enrollee's right to file a grievance.

(c) The grievance procedure shall include:

(1) Identification of the reviewing body and an explanation of the process of review;

(2) An initial investigation and review;

(3) Notification within a reasonable amount of time of the outcome of the grievance; and

(4) An appeal procedure.

(d) The managed care plan shall set reasonable time limits for each part of the review process, but in no case shall the review extend beyond thirty (30) days.

(e) The managed care plan shall provide for expedited review for cases involving an imminent, emergent or serious threat to the health of the enrollee:

(1) The plan shall immediately inform the enrollee of such right;

(2) The plan must provide the enrollee with a written statement of the disposition or pending status of the grievance within seventy-two (72) hours of the commencement of the review process.

(f) The managed care plan shall report to the department of commerce and insurance, the number of grievances and appeals received by the plan within a specified time period, including if applicable, the outcomes or current status of the grievance and/or appeals as well as the average time taken to resolve both grievances and appeals.

SECTION 13. This act shall take effect July 1, 1997, the public welfare requiring it.